Lawyer Discipline in Transition
What You Need To Know About the Proposed Changes
Credentialing and Peer Review
A Primer for the Non-Health Care Attorney

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n the author’s experience, Arizona attorneys representing physicians in a variety of contexts—general business advice, regulatory matters and even medical malpractice litigation—are poorly equipped to advise physicians in connection with their hospital privileges. Credentialing and peer review occurs in all Arizona hospitals and therefore affects thousands of physicians practicing in this state. This article addresses not only the legal bases for credentialing and peer review but also the remedies available for physicians against whom “Adverse Actions” have been taken, the confidentiality surrounding the entire process and the immunities afforded all participants. Health care lawyers should not be the only Arizona practitioners who are comfortable with this topic.

Why Credentialing Is Required
The Joint Commission (formerly JCAHO) is a not-for-profit agency that accredits hospitals that meet rigorous standards governing virtually every aspect of hospital services. Its mission statement, prominent on its Web site, reads, “The mission of The Joint Commission is to continuously improve the safety and quality of care provided to the public through the provision of health care accreditation and related services that support performance improvement in health care organizations.”

Compliance with Joint Commission standards is important to participating hospitals for a variety of reasons, not the least of which is that a hospital that meets these standards is deemed to meet the Medicare Conditions of Participation, which require hospitals to receive Medicare funding. (There are other means of meeting Medicare standards, but that topic is beyond the scope of this article.)

Joint Commission Medical Staff Standards require credentialing at the time of initial application and at least every two years thereafter. CMS Conditions of Participation for hospitals participating in the Medicare program also require credentialing and recredentialing. Finally, Arizona law requires hospitals to conduct peer review. Because quality data are gathered constantly, peer review never ends.

Arizona Law Requirements
Arizona’s peer review statute requires hospitals and outpatient surgery centers to organize into committees to review the professional practices within the hospital, for the purpose of reducing morbidity and mortality and for improvement of the care of patients provided in the institution. The purpose of this is to reduce morbidity and mortality and to improve patient care provided in the institution. Thus, by statute, the actual conduct of credentialing and peer review is delegated to the medical staff. The statute makes clear that peer review begins with the initial application for medical staff privileges, by specifying that it applies to “individual health care providers practicing in and applying to practice” in an Arizona hospital or outpatient surgery center.

Credentialing packets are assembled by hospital employees in the Medical Staff Services (MSS) office. These packets include proof of education, training and experience, board certification, professional references, medical malpractice litigation experience and proof of insurance. MSS either conducts primary verification of the applicant’s credentials by contacting medical schools, residency programs, professional societies and references, or it contracts with credentialing agencies such as Greater Arizona Central Credentialing. Once verification has been accomplished, the application for privileges is deemed “completed.”
Completed applications are forwarded to the Credentials Committee, usually comprised of experienced medical staff leaders. The committee makes an independent decision on the applicant's qualifications to exercise specifically delineated privileges. Following a personal interview, the committee forwards the completed application to the clinical department (e.g., Department of Surgery) for its approval of the applicant's education, training, and experience. In some hospitals, the application goes back to the Credentials Committee before going on to the Medical Executive Committee (MEC); in others, it goes from the department directly to MEC. The final step in obtaining medical staff approval is the MEC's recommendation to the hospital governing body. Only the governing body can grant hospital privileges.

**Negligent Credentialing Liability**

Since 1972, Arizona hospitals have had independent liability for failing to credential physicians effectively. The hospital is not held liable for the negligence of its medical staff member but, instead, for its independent negligence in allowing that practitioner to exercise clinical privileges.

In the trial of such a case, medical negligence must first be proven; then, negligence by the hospital becomes relevant. A negligent credentialing claim could include a claim for punitive damages if the hospital’s conduct was egregious. Under Arizona law, punitive damages can be awarded only by clear and convincing evidence that the hospital consciously disregarded a substantial risk of significant harm or consciously pursued a course of conduct knowing it created a substantial risk of harm.

**Arizona Public Policy**

Numerous Arizona appellate opinions stress the importance of peer review and the need for strict confidentiality. Our courts acknowledge that peer review is difficult and often distasteful, but absolutely necessary to maintain quality health care. For that reason, the statute provides for strict confidentiality and immunity from damage claims.

**Statutory Confidentiality**

All proceedings, records and materials generated as part of credentialing or peer review are confidential and are not subject to discovery in litigation. But there are two exceptions.

First, the Arizona Medical Board (AMB) and the Arizona Osteopathic Board (AOB) are entitled to receive and consider confidential peer review materials. By statute, board investigation files themselves are confidential and inadmissible as evidence. Arizona appellate decisions define this confidentiality as absolute.

Second, a physician challenging an Adverse Action against hospital privileges may obtain the peer review file for review by a superior court judge. The record in such a superior court review may be sealed by court order to avoid disclosure of confidential documents. With the exception of such a lawsuit, peer review documents are confidential and inadmissible in court.

Confidentiality extends to the identities of the participants in peer review, the issues considered and the basis for any action taken. The Arizona Court of Appeals explained why this degree of confidentiality is necessary in *Yuma Regional Medical Center v. Superior Court:* “Review by one’s peers within a hospital is not only time consuming, unpaid work, it is also likely to generate bad feelings and result in unpopularity.”

Only the fact of peer review, the date and place it occurred and the ultimate outcome are subject to discovery. The peer review statute survived a constitutional challenge that its strict confidentiality has the effect of abrogating a cause of action in violation of the anti-abrogation clause of the Arizona Constitution.

Arizona appellate decisions refer to peer review confidentiality as a “privilege.” In some states that reference is correct. In the author’s home state of Texas, for example, the peer review statute specifically addresses the issue of waiver and, thus, is a true statutory privilege.
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Statutory Immunity
Neither the facility nor anyone participating in peer review, including anyone who supplies information, may be subjected to a civil suit seeking monetary damages. The sole remedy under Arizona law is an action against the hospital for an injunction reinstating clinical privileges or reversing a disciplinary decision by the hospital.

This state statutory immunity is bolstered by the federal Health Care Quality Improvement Act (HCQIA) of 1986. By meeting basic standards of “fundamental fairness,” all participants in peer review are protected by a potent federal immunity defense for damage claims, such as antitrust or defamation. HCQIA creates a statutory presumption of compliance with its Fairness Standards. The practitioner must rebut this presumption by a preponderance of the evidence.

Certain claims, such as civil rights (42 U.S.C. §§ 1981 et seq., 1988 et seq., 2000e et seq.) and Americans With Disabilities Act (ADA) claims (42 U.S.C. § 12101 et seq.) do not fall within this immunity. In addition, a hospital can lose HCQIA immunity for three years if it fails to report to the National Practitioner Data Bank (NPDB), as required by federal regulations. Generally speaking, reportable actions are those affecting clinical privileges for 30 days or more; those based on concerns over clinical competence or conduct; or the resignation of privileges during, or to avoid, investigation.

Individual Liability Exposure
Although individual members of a committee could be named defendants in a lawsuit alleging antitrust violations or defamation, it is the hospital, as an entity, that has the statutory duty to conduct peer review. Thus, it is the hospital that faces liability exposure. For that reason, there is no need to name individual defendants. Committee members commonly are insured under the hospital’s policy and are not required to retain their own counsel if they are named.

Denial of Medical Staff Membership
There is no right to medical staff membership. The applicant carries the burden to establish that he or she meets the membership criteria set up by a given medical staff. There are numerous bases for denial of medical staff membership, including the existence of sufficient practitioners within a given specialty. Denial of medical staff membership is defined as an Adverse Action under most hospital Fair Hearing plans and is NPDB-reportable if the denial is based on professional competence or conduct.

Actions Against Existing Medical Staff Privileges
Hospital bylaws often empower the clinical departments to review cases for educational purposes. Occasionally these departments will refer matters to the MEC for further investigation and possible disciplinary action. These referrals also may come from hospital administration.

Arizona appellate decisions have held that the bylaws represent a contract between members of the medical staff and the hospital. In revoking, suspending or otherwise limiting a practitioner’s privileges, the hospital must substantially comply with its bylaws. Such actions are considered Adverse Actions under hospital Fair Hearing plans and are NPDB-reportable if the denial is based on professional competence or conduct and affects the practitioner’s privileges for 30 days or more.

The Fair Hearing
In compliance with the Fairness Standards of HCQIA, hospitals are required to provide a hearing procedure that meets a “fundamental fairness” standard. This standard is somewhat lower than the requirements of constitutional “due process,” but Arizona law does recognize a substantial property interest in medical staff privileges.

To comply with the Fairness Standards, Fair Hearing plans should include the right to counsel, the right to call and cross-examine witnesses and to offer other forms of evidence. Procedural and evidentiary rules are not strictly applied. Fair Hearing panel members, usually physicians and distinguished members of the community, are entitled to consider essentially any evidence they deem relevant. Both sides have the right to submit a closing memorandum. Individual Fair Hearing plans may provide other basic hearing rights.

At a Fair Hearing, the medical staff, acting through its MEC, generally has the burden of establishing why it took action and that this action was reasonable under the circumstances. The burden of proof ordinarily shifts to the practitioner who must show that the action was not justified by the evidence or was arbitrary and capricious. Fair Hearing plans provide for the preparation of written findings and for the right of appeal before the matter goes back to the MEC. Ordinarily, medical staff bylaws permit the MEC to accept, reject or modify the recommendations of the Fair Hearing panel. The MEC then makes its final recommendations to the hospital board. By providing this degree of fundamental fairness, the hospital cements its HCQIA immunity argument.

Fair Hearings often are conducted by hearing officers—generally experienced health care lawyers who play a role similar to that of a judge. They brief the Fair Hearing panel members on the law, rule on objections and ensure compliance with HCQIA Fairness Standards. They also serve the important role of assuring absolute confidentiality by instructing all participants on its importance.

Conclusion
The Arizona Legislature and Congress have established a comprehensive system that balances the public’s need for quality health care with individual physicians’ rights to protect their valuable property interests. The system is praised and cursed for
its confidentiality. Indeed, trial judges often find its "secrecy" unacceptable, particularly in light of Arizona’s long-standing commitment to full disclosure of relevant facts. From the plaintiff’s perspective, proof of a negligent credentialing case under \textit{Purcell v. Zimbelman}\textsuperscript{9} is extremely difficult. However, confidentiality is vital to the efficacy of peer review. It is for that reason that Arizona appellate decisions uniformly protect statutory confidentiality and inadmissibility absolutely.

Federal courts, reviewing cases under federal-question jurisdiction, often with pendent state claims, take a hands-off approach, finding statutory immunity unless clear violations of the HCQIA Fairness Standards can be demonstrated by the affected physician. Because hospital bylaws are drafted to incorporate these standards, this is an appropriate means of judicial oversight.

Hospitals are uniquely qualified to review the competence and performance of their medical staff members. The court system serves an important role by ensuring that basic state and federal rights are protected, while at the same time looking to the hospitals of Arizona to protect the public from incompetent or unqualified medical practitioners.\textsuperscript{10}

\textsuperscript{9} See 2009 Comprehensive Accreditation Manual for Hospitals (CAMHE).
\textsuperscript{10} U.S.C. § 36-446.02(A) (2009).
\textsuperscript{11} Id. at 341; Tucson Med. Ctr., Inc. v. Misevich, 545 P.2d 958, 960 (Ariz. 1976).
\textsuperscript{12} Id. at 341; Tucson Med. Ctr., Inc. v. Misevich, 545 P.2d 958, 960 (Ariz. 1976).
\textsuperscript{14} Id. at 341; Tucson Med. Ctr., Inc. v. Misevich, 545 P.2d 958, 960 (Ariz. 1976).
\textsuperscript{15} Id. at 341; Tucson Med. Ctr., Inc. v. Misevich, 545 P.2d 958, 960 (Ariz. 1976).
\textsuperscript{17} Id.; Ariz. Rev. Stat. Ann. § 32-1451.01(C)-(E) (AMB); § 32-1855.03(C)-(E) (2009) (AOB).
\textsuperscript{19} Ariz. Rev. Stat. Ann. § 36-446.01(A); § 36-446.02(B).
\textsuperscript{20} Id. § 36-446.01(B).
\textsuperscript{21} See id.; § 36-446.01; \textit{Yuma Reg'l Med. Ctr.}, 852 P.2d at 1259-60.
\textsuperscript{22} 852 P.2d at 1259 (quoting \textit{Humana}, 742 P.2d at 1386).
\textsuperscript{23} Id. at 1261.
\textsuperscript{24} \textit{Humana}, 742 P.2d at 1386 (holding that the Peer Review Act merely regulates, not abrogates, a plaintiff's claim against a hospital for negligent supervision and thus does not violate Ariz. Const. art. XVIII, § 6).
\textsuperscript{25} See, e.g., \textit{In Re The Usurp of Tex. Health Ctr. at Tyler}, 33 S.W.3d 822, 826-27 (Tex. 2000).
\textsuperscript{26} In a future article, the author may address the difference between statutory confidentiality in peer review and the common law privileges codified in Title 12 of the Arizona Revised Statutes.
\textsuperscript{28} Id. § 36-446.02(B); \textit{Samaritan Health Sys.}, 981 P.2d at 588.
\textsuperscript{29} 42 U.S.C. §§ 11101-11152 (2006).
\textsuperscript{30} Id. § 11111(a)(1) (2006) (immunity provision); § 11112(a) (2006) (Fairness Standards); \textit{Austin v. McNamar}, 979 F.2d 728, 733, 737 (9th Cir. 1991) (HCQIA immunity provision applicable to antitrust claims); see \textit{Patterson v. St. Francis Hosp.}, 581 S.E.2d 551, 554, 557 (Ga. Ct. App. 2003) (HCQIA immunity provision applicable to defamation claims).
\textsuperscript{31} 42 U.S.C. § 11112(a); \textit{Austin}, 979 F.2d at 733-34.
\textsuperscript{32} Id. § 11112(a).
\textsuperscript{33} Id. § 11111(a)(1) (1998); \textit{Austin}, 979 F.2d at 733 (civil rights claims); see \textit{Fretich \textit{v. Upper Chesapeake Health Inc.}}, 313 F.3d 205, 214 (4th Cir. 2002) (ADA claims); \textit{Menonkowitz v. Pottown Med. Ctr.}, 154 F.3d 113, 116-22 (3d Cir. 1998) (ADA claims); \textit{Tyrone v Oregon Anesthesiology Group}, PC, 2007 WL 1731475 (D. Or. 2007) (unreported) (ADA claim).
\textsuperscript{34} 42 U.S.C. § 11111(a).
\textsuperscript{35} Id. § 11133(a) (2006); Health Res. & Serv. Admin., Nat'l Practitioner Database Guidebook, E-28 (2001) (hereinafter Guidebook).
\textsuperscript{38} See id.
\textsuperscript{39} 42 U.S.C. §§ 11133, 11151(1), (9) (2006); Guidebook, supra note 34, at E-28.
\textsuperscript{42} U.S.C. §§ 11133, 11151(1), (9) (2006); Guidebook, supra note 34, at E-28.
\textsuperscript{43} 42 U.S.C. § 11112(a) (2006); \textit{Austin}, 979 F.2d at 733, 737.
\textsuperscript{46} Id. § 11112(b)(3)(C)(i),(ii) (2006).
\textsuperscript{47} See Bock, 702 P.2d at 257-58.
\textsuperscript{48} See id.
\textsuperscript{49} \textit{Austin}, 979 F.2d at 733-37.
\textsuperscript{50} 500 P.2d at 335.